

Hyperglycemic Hemichorea/Hemiballism

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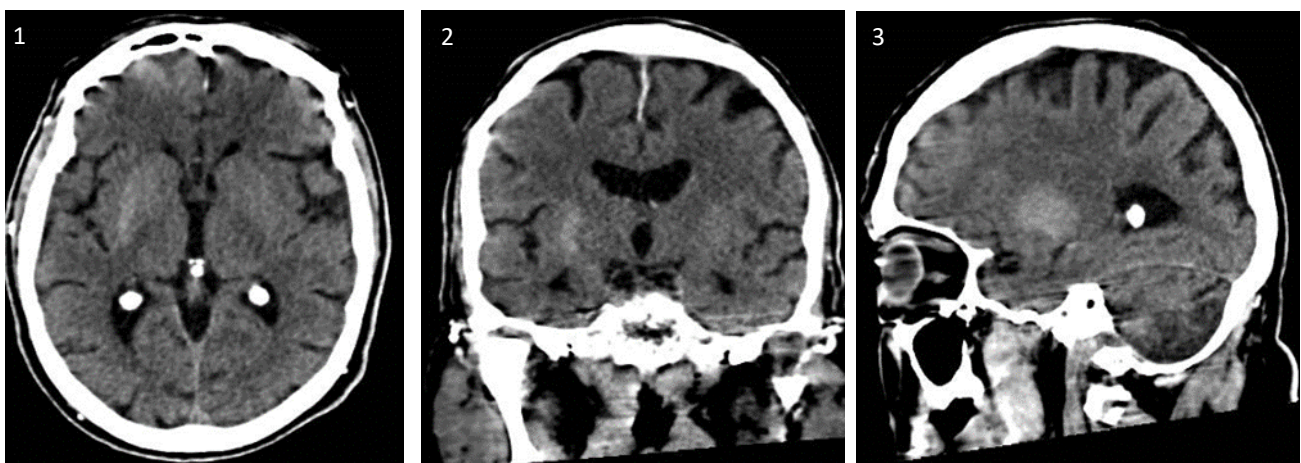
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We present a 70-year-old male, with a history of arterial hypertension (HTN), non-insulin requiring (NIR) type II diabetes, right hallux paronychia, anticoagulated due to atrial fibrillation (AF), ischemic stroke in 2018; who consulted in our center in August 2023, due a condition characterized by abnormal choreic/ballistic movements in the left hemi-body, which intensified during the subsequent 72 hours after onset. CT scan showed hyper-density in the right globus pallidus, in axial, coronal and sagittal slices. (Fig.1, 2 & 3). Blood tests showed non-ketotic hyperglycemia. Infectious focus of the hallux was drained and antibiotic and insulin therapy were provided. The patient normalized glucose values and completely improved the movements.

Metabolic disorders (hyperglycemia) are the second most frequent cause of acquired hemichorea/hemiballism, after vascular disorders. They can occur as an initial manifestation of diabetes or due to poor control of an already known disease.

The frequency of this complication is estimated at less than 1/100.000 individuals. The clinical picture is characterized by a triad of hyperglycemia, acute onset choreic movements (generalized or hemicorporal), and lesions of the lenticular nucleus (uni or bilateral), which usually resolve when glyceic values are normalized.



(Fig.1, 2 & 3) CT brain scan showed hyper-density in the right globus pallidus, in axial, coronal and sagittal slices.

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